UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF LOUISIANA

SHREVEPORT DIVISION

AKEEM HENDERSON and JENNIFER ALEXANDER, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE SUCCESSION OF A.H.

CIVIL ACTION NO. 5:19-CV-00163

VERSUS

JUDGE ELIZABETH E. FOOTE

MAGISTRATE JUDGE MARK L. HORNSBY

WILLIS-KNIGHTON MEDICAL CENTER d/b/a WILLIS KNIGHTON SOUTH HOSPITAL

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DEPOSITION OF

JACQUELYN WHITE, M.D.

February 12, 2020

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Taken at:

Health Hut
310 West Mississippi Avenue
Ruston, Louisiana

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Reported by: Janet McBride
Certified Court Reporter
Certificate No. 27006

S T I P U L A T I O N S

It is stipulated and agreed among counsel that the deposition of JACQUELYN WHITE, M.D., is taken by plaintiffs, AKEEM HENDERSON AND JENNIFER ALEXANDER, INDIVIDUALLY AND AS ADMINISTRATRIX OF THE SUCCESSION OF A.H., pursuant to Notice, and may be used for all purposes permitted by the Federal Code of Civil Procedure. All objections except as to the form of the question and responsiveness of the answer are reserved until such time as the deposition is offered and introduced into evidence. The deponent elected to read and sign her deposition.

A. Yes, sir.

Q. And when was that?

A. About a month ago.

Q. And I'm not looking for exact dates. I'm just trying to piece together some information. Okay. And what were you asked to do?

A. To review a case for him.

Q. And what were you looking for in your review?

A. To see if there was an EMTALA violation, to evaluate a case to see if there was an EMTALA violation.

Q. I understand you testified in a couple of different cases in court.

A. I have. Yes, sir.

Q. Did either one of these cases involve EMTALA?

A. No, sir.

Q. Out of curiosity, what were those cases about?

A. One was about a lady that had a stroke and was sent home initially and then came back with her symptoms, and then was over that. Another one was about a patient that had a heart attack or came in with chest pain, shortness of breath, was discharged. And then the third-- I think I've had two or three. And then the other one was chest pain, he came in and had a heart attack, but it was the timing of the cardiologist involved and going to the cath lab.

Q. And who were you retained by, the plaintiff or the

defendant in those cases?

A. The defendant in all of them. Yes, sir.

Q. Have you ever testified for a plaintiff?

A. I've not testified for one. No, sir.

Q. How do you get contacted or connected, I guess is a better word, with the legal world? Do you advertise or--

A. No, sir. I do not advertise. Those previous ones were from-- There was a nurse in Jonesboro that did a lot of medical reviews, and my name was given to her so I've looked at several charts for her. And then those two cases that came from Florida were from a colleague of hers that needed an emergency medicine physician to review. The one in Opelousas, I was on the medical review panel and so I was not asked, but told that I needed to come and do a deposition on why we--why we--how we chose our disposition of that case.

Q. You mentioned a medical review panels, and I think I read that in your report that you had done several.

A. Yes, sir.

Q. And I'm not looking for exact numbers, but when you say several, what are we talking about?

A. I'd probably say at least twelve to fourteen.

Q. Did any of those involve EMTALA?

A. They did not.

Q. Again, out of curiosity, did any of those cases

There are several vital signs you look at, as well as your examination, as well as your history of present illness. It all plays a part. Yes, sir.

Q. So we're dealing with examination, vital signs and what else is in the components that--

A. History.

Q. History. Okay. I noticed that in your report, that you did not mention that you had reviewed the death certificate. Did you--

A. I didn't. I do not remember seeing the death certificate. No, sir.

Q. Did you review the autopsy?

A. I did not. No, sir.

Q. Did you review the protocol for the hospital as far as administering oxygen?

A. No, sir.

Q. Did you review the interpretative guidelines for EMTALA?

A. I read over some EMTALA. I'm not sure if I read the complete EMTALA, but I did look at some things about EMTALA.

Q. Tell me what you recall about reading the EMTALA that you--

A. May I look at my notes while I'm telling you that?

Q. Yes. You may. Please do.

A. Okay.

Q. I've been practicing law for forty-four years and I never have figured that out.

A. Okay. I will tell you from an emergency medicine physician,--

Q. Please.

A. --if they're stable enough to be discharged, or do I feel the patient needs to be admitted. That's a primary concern on anyone that's having any kind of emergency medical condition is can they continue treatment at home or do they need to continue treatment in the hospital. Have you resolved it? Have you improved it? A patient doesn't have to be back to baseline. Are they improved well enough that they can continue the treatment at home? That's one of our first things that we think of when we have someone with an emergency medical condition.

Q. What is the baseline for this particular child?

A. A base-- Well, I--I don't know the baseline of a-- of this particular child. Was the child improved or did the--did the provider feel like the patient was stable enough to be discharged. It is-- According to the EMTALA definition of within reasonable medical probability, and I feel that this patient was, after reviewing the chart in completeness.

Q. All right. If we're going to tell the jury here's

Q. Okay. Let's go to the respiratory rate on initial taking of the vital signs. Is that average or normal or high average or--

A. I will say the normal for a four-year-old is around twenty-two to thirty-four. So it is barely elevated. Yes, sir.

Q. Okay.

A. She was slightly tachypneic. It's a very common thing with asthma exacerbations. Yes, sir.

Q. Tachypneic is what?

A. Breathing a little fast.

Q. And do you know why she was breathing fast? I mean, the physiology of that.

A. Because she was--she was wheezing which is congestion in the lungs which is having trouble getting the oxygen in there because of the inflammation. So it causes them to breathe a little faster.

Q. Now, the medication, Albuterol. Is that right?

A. Albuterol. Yes, sir.

Q. Albuterol. Okay. Thank you. You say that can increase the--

A. It can--

Q. --heartbeat.

A. --slightly. Yes, sir.

Q. So you really, it's fair to say that upon entry in

percent?

A. In a child that's having trouble breathing, it tells me that they're in need of some treatments as well as some supplemental oxygen. So that patient was probably--and I think it shows in the record--put on some supplemental oxygen as well as given the DuoNeb treatment.

Q. Okay. How would you measure the ninety-one percent?

A. You measure it--you put a--it's a pulse ox that you put on their finger and it's-- Most of the time, it stays on the patient the entire ER visit or until they feel pretty sure that they don't need it anymore. But most of the time, it's on the entire visit.

Q. How would you know that you don't need it anymore?

A. The child's running around the room, pulling it off. They're playful. They're active. And they've been at ninety-nine, they've been at ninety-five, they've been at whatever, you feel comfortable enough taking it off. It's part of the whole picture.

Q. So would it be fair to say that you believe that the oxygen level was monitored the entire time she was in the emergency room?

A. That's how most patients are. There's no way to tell from this record. You'd have to go to their facility and see. Most facilities now have the monitor in the rooms where it's continuous.

at their policies and protocols recently. About when to administer it? How to administer it?

Q. Well, for instance, Glenwood Hospital-- How often do you work there?

A. I work several shifts a month there.

Q. You're not familiar with any policy that relates to the level of oxygen in a patient's body?

A. A policy related to the oxygen in their body?

Q. Oxygen level in the blood. You don't know--

A. I don't--I don't think you're-- You mean of when to give them the oxygen, of when we have to--

Q. Yeah.

A. --put a patient on it?

Q. Let's go with that.

A. I don't--I don't know of their--of when it--of a certain level. Because every--every patient's going to be deemed different of when they need the oxygen. It's probably at the discretion of the provider. But I haven't looked at their policies. No, sir.

Q. Are you aware in your review of the EMTALA laws whether or not violation of hospital policy is prima facie evidence?

A. I did not see anything about-- No, sir. I'm not.

Q. You hadn't looked at that. Did you consider that?

A. No, sir.

Q. And is it fair to say you have no clue what the policy was of Willis-Knighton South as far as administering oxygen--

A. No, sir. I do not know their policy. Right.

Q. Okay. What other hospital did you say you worked at?

A. Here in Ruston at Northern Louisiana Medical Center.

Q. Are you familiar with the protocol of that facility as far as administering oxygen?

A. No, sir.

Q. How about in med school when you were going through, do you recall any protocols that were suggested by the instructors as far as administering oxygen?

A. No, sir.

Q. Would it be fair to say that in your opinions any type of protocol or hospital policy has been excluded?

MR. ROBISON: Object to the form.

MR. BANKS: Yeah. That's a bad question. Let me strike that and see if I can ask that a little better.

Q. Okay. In rendering your opinions in this case, is it fair to say and to tell the jury in this case that you gave no concern as to the policy of Willis-Knighton hospital as far as the protocol for administering oxygen?

A. That is fair to say.

A. This protocol is for inpatients. In the ER, it's different. And if they do have a protocol, I would think it would be different than this protocol.

Q. Okay. Well, but you are an emergency room physician and you're not familiar with any protocol in the places where you work.

A. I have not read those protocols, if that's what you're asking. So I don't feel comfortable answering particular questions about them.

Q. Right.

A. I know we have protocols.

Q. Okay. I'll represent to you that the "White 1" that you're holding there is the protocol for Willis-Knighton South. And if I'm understanding correctly, what you're telling me is that's the admission--that's for hospital patients--

A. I would assume that this is for the hospital patient. I wouldn't-- This says that you're to reassess the patient daily on 7:00 to 3:00 shift. So that would not be pertaining to the ER and that's the first number one in the protocol. So that's why I'm assuming this is inpatient--

Q. Right.

A. --protocol.

MR. ROBISON: I just want to object to the

A. But I would say probably in the seventies.
Q. Do you know what this child died of?
A. I did not read the autopsy report. I just read that ER visit and then that hospitalization. Yes, sir.
Q. So you have no idea what caused the death of this child?
A. I do have an idea because I read the ER chart and the hospitalization.
Q. Okay. What do you think this child died of?
A. Of respiratory failure.
Q. Suffocation?
A. I would not use the word suffocation.
Q. What's the difference between respiratory--
A. I don't know--
Q. --failure and suffocation?
A. I don't have a medical answer for that.
Q. Okay.
A. Just because we don't use the word suffocation in--in--
Q. Okay. It says in "White Number 1," that if these Sa02 less than ninety-two percent on room air and/or Pa02 less than fifty on room air, you place the patient on minimum level 02 and titrate to maintain saturation of ninety-two percent or more.
A. Yes, sir.

the chart and nor does the ninety-nine percent say that it was on oxygen. Usually, if a patient's on oxygen with a pulse ox, they're going to say on two liters, on one liter, on bi-pap, on ventimask.

Q. So you think that the ninety-nine percent was not on room air or it was on room air?

A. I do think it was on room air. Yes, sir. I do.

Q. And the reason being again?

A. Because she was--went by stretcher off oxygen to radiology. And if she was doing well enough to go then, I do not see the need for her to put back on it. I will say that when she came back, she had a breathing treatment done at 3:16, and it does not say anywhere that she had to go back on her oxygen after that.

Q. Okay. And was there another set of vital signs taken?

A. Those were the only two that I saw.

Q. Okay. Well, let's go to the second set of vital signs.

A. Yes, sir.

Q. Were those normal?

A. Those were the--the guidelines that I saw, her respiratory rate thirty-four is within the normal. It's the high normal. Her ninety-nine percent is definitely normal. Her one forty-six could be within normal if you

look at different sites, and I apologize for not having a set normal with me. It's improving whether it's the upper limits of normal or just above. I'm not sure. But the most important thing to me was that it was coming down.

Q. Okay.

A. Yes, sir.

Q. And that was at three--

A. 3:23.

Q. 3:23.

A. Yes, sir.

Q. Okay. And twenty-two minutes later, she was discharged home?

A. Her order was written there at 4:00, I believe, is when she actually left the facility, or 3:59. The nurse actually discharged her at that time.

Q. You see the 3:44 entry of Decadron steroid?

A. Yes, sir.

Q. What is a Decadron steroid?

A. A steroid is an anti-inflammatory which helps to treat the inflammation in the alveoli in the lungs that's causing the wheezing and the trouble breathing. Steroids are used as the second step in an asthma exacerbation, if needed. Sometimes, we give just Albuterol. Sometimes, we give Albuterol with steroids. This patient was given a shot of steroids prior to discharge as well as a

be nothing, which can be acute, which can be inflammation which can be fluid which can be infection. It's a very non-specific.

Q. Is it indicative of pneumonia?

A. No, sir.

Q. Doctor, can you think about that a second and tell me again.

A. Perihilar infiltrates are not indicative of pneumonia. No, sir.

Q. All right. It's an inflammation?

A. Yes, sir.

Q. Okay. And that inflammation that was showing up in the chest x-rays at 3:39 wasn't going to be treated until we administered the steroids at 3:44. Correct?

A. Some of it. Yes, sir. And--

Q. And that inflammation was going to remain in place and really it's kind of an unknown until six or eight hours later. Correct?

A. It's not an unknown because she'd had that before and that's a very common finding for asthmatics, and she'd had it before and had done well.

Q. Let me ask you, Doctor, just out of curiosity. No one has a crystal ball and I'm certainly not going to hold you do that, but do you think if you would have been there, this child would've died?

hospital, who receives some Albuterol and receives a steroid to combat the inflammation and then, twenty-two minutes later, discharged without any vital signs. Is that standard, Doctor?

A. Without any vital signs documented? I believe that patient was still on a monitor as part of his--

Q. Oh, you do?

A. --reassessment. I do. Because there's no reason to take him off of the monitor before you discharge them.

Q. Where is that in the notes?

A. I don't-- I said I believe that.

Q. But it's not in the record?

A. I do not see that. No, sir.

Q. You're making that up?

A. I'm not making it up. I told you I didn't see it. My assessment of reading the chart was the-- The provider wrote that he reassessed the patient. He didn't say if he did have vitals or didn't have vitals. There's none documented in there. I totally agree with that. Yes, sir.

Q. Is there a rule of medicine that if it's not documented, it didn't happen?

A. No, sir. That's a rule of lawyers, not of medicine. I don't mean to be crude, but it--

Q. That's fine.

A. --really isn't and we're--and we're awful. When an

ER is busy that we don't always document like we're supposed to.

Q. I see in your report--or I'm sorry--in the medical records, I see a notation at 3:50 a.m. that the patient's condition has returned to baseline. Do you see that? Do you remember that?

A. The provider wrote that?

Q. Right.

A. Yes, sir.

Q. What does that mean?

A. To him, he feels like the child's back to their usual self. If the child was playful, if the child was active, if there was no further wheezing, then, to him, it was the child's baseline.

Q. It doesn't mean anything about vital signs?

A. It could be.

Q. Okay. What would be the relationship?

A. You would have to ask-- I mean, that provider, what his definition of that is, sir.

Q. Well, what is your definition? When you read that in the record, what did you believe the baselines were as so far as vital signs?

A. That he felt the child was back to their usual status. If--if this child is known to these--to these providers, as you said, and they've seen her--seen her

before, and we've all seen an asthmatic and we've seen a healthy child, and we've seen a child in respiratory distress, if she's back to baseline, that tells me she's interacting with mom, she's not having trouble breathing. It could've been, you know, you'll have to ask him about his baseline. That's what it--that's what it appeared to me.

Q. Okay. In looking at the--

A. Because, sometimes, we-- Can I just add this?

Q. Oh, yeah. Sure.

A. Sometimes, we do discharge people that are not back to baseline, but they're improving and they're stable enough to go home. So that holds a lot to me that he said back to baseline, that it's not just-- The child had been discharged prior, if you read some of those other ones. There still have some slight wheezing, but much improved, or could've still had tachypnea. You don't always wait till they're totally at baseline.

Q. Did you notice in some of those prior visits that she was hospitalized with a ninety-five percent oximeter reading?

A. I did not--I don't remember specifically. I'm not surprised because that's just one of several things that you look at.

Q. And what would be the others that you look at?

A. Her respiratory distress, how she responded. If you look at your protocol, at the bottom of it, it says a pediatric child needs oxygen and I think it says pediatric is to have an 02 maintained at ninety-five or greater. So that's kind of borderline if they're at ninety-five. The good thing is our child was at ninety-nine when she went home.

Q. Yeah. And you are convinced that that ninety-nine percent is after a washout period of time where the room air is allowed to get back into the lungs?

A. Yes, sir. Because-- And what helps me even more so is the fact that she went to radiology at least thirty, forty-five minutes prior off the oxygen. So if she was doing well then, there's nowhere in there that states that she needed to be placed back on the oxygen or having any trouble.

Q. Okay. Coming back to what we've talked about here before, in those prior visits in the emergency room that you reviewed, did you see any mention of a protocol in there?

A. Did I mention a protocol? No, sir.

Q. Do you see any mention of protocol in those--

A. No, sir.

Q. --prior visits?

A. No, sir.

A. Yeah. Okay. Yes, sir.

Q. I'm talking about between the discharge from Willis-Knighton South and the time when the patient, the four-year-old patient, is transported by ambulance to Willis-Knighton Bossier. What happened to the child's body? What was going on inside?

A. I would really-- Before I answer that, would like to read the death certificate to see what the coroner actually said it was. I mean--

MR. HUTTON BANKS: Autopsy or death certificate?

WITNESS: The autopsy report.

A. I mean, to just give you off the cuff, if I can help explain it to the jury. I don't think-- I don't feel like the patient was inappropriately discharged. I think it's an awful, awful sad case. I think-- Asthma-- I've seen several people die from it. It's a very unfortunate-- It is a-- It's very sad but it--

Q. Is it painful, Doctor?

A. It's not-- Is it painful to have trouble breathing? I think it's uncomfortable. Have I had asthma? I do not have asthma.

Q. Would you tell the jury that this child did not suffer in between the discharge--

A. I would not tell the jury that.

very--in much distress. Even if you're not hearing it, they're not sitting here like you and I. They're going to be very uncomfortable.

Q. Did you notice that the family, as noted in the records, observed respiratory failure.

A. I don't understand what you're saying. They observed it when?

Q. When they called the ambulance?

A. I did not see the run sheet of the call. I'm reading the ER chart and I don't--I don't know what they said when they called. Do you have the run sheet of when the patient was picked up by the ambulance?

Q. I don't know if we have that, Doctor. I'm not sure.

A. Okay. Well, I will say that on the ER note that the doctor wrote that CPR was not being done by the bystander, so I'm assuming that the patient did not code in front of the parents or they didn't recognize it and that the ambulance guys recognized or it occurred in front of the ambulance guys.

Q. Okay. You think also, Doctor, coming back to what we talked about early-- Well, before we leave that. Do you think a four-year-old can explain to a doctor that "I'm feeling better, Doctor. I'm okay."

A. They can say, they can show it, they can act it. I think you can say, "Do you feel better?" and they can smile

or say yes or run around the room, which shows you they're feeling better. Drinking their juice. They're feeling better. Yes, I do.

Q. Okay. Did you see where this patient was running around the room?

A. I didn't see it documented. No, sir.

Q. Did you see where she was drinking juice?

A. No sir.

Q. Did you see any of those things that you're talking about that indicated to you that the patient's fine?

A. No. But I saw the note of the reassessment that the nurse said that the patient was feeling better. So you'd have to ask the nurse what she was observing that made her say that. But that's how I reassess.

Q. I understand.

A. Yes, sir.

Q. I want to cover just a couple of quick questions and answers, if you will, Doctor, just to kind of cover some ground here. Tell me whether you agree or don't agree, please?

A. Yes, sir.

Q. Vital sign assessment is essential in determining a patient's health status?

A. Where are you reading this from? Is this from a medical book?

Q. If we wanted to open it up in front of the jury and read from it and we wanted to tell the jury that this source, this medical source that Dr. White, as the bible, it would tell us how not to discharge an unstable patient. What text would you go to?

A. I wouldn't be able to give you a name of that. I use very-- We all use different texts as well as our clinical judgment on saying this.

Q. Okay. Which text or medical authority would you rely on to tell you when to not discharge an unstable patient?

A. I don't have one over the other that I would give you.

Q. Well, let's do it this way. Give me two or three of them that you really consider authorities insofar as discharging an unstable patient.

MR. ROBISON: Wait, what do you mean by discharging an unstable patient.

A. You mean appropriate treatment of the emergency medical care?

Q. No. I'm talking about. This is how we go about--

A. Appropriate discharging?

Q. This is how we go about making sure that we do not discharge a patient in an unstable condition. This is it. This is the page we ought to read. What authority do you

Q. That you didn't get?

A. The one I didn't get was the run sheet.

Q. And what was the importance--

A. The ambulance. To know what was going on at the house, to know what symptoms--what she presented as when they got there, to know what they did or attempted to do enroute. It sometimes will help with the-- When a--when a patient comes in in arrest, the chart is not always complete because they're worried about trying to save the child's life. So, sometimes, the run sheet can give you a better history or story. So I just wanted that for completeness.

Q. Okay. Why did you not think that the 02 protocol was not sufficiently important to review with respect to your opinion of whether the hospital violated EMTALA in this case?

A. Because when the patient was discharged, the patient was stable with ninety-nine percent saturation. So there was not a question in my mind that they followed the protocol or not. They treated the patient who had an emergency medical condition and the patient was stabilized. So I didn't think to ask for the 02 policy.

Q. Okay. Have you ever been sued in a civil lawsuit alleging medical malpractice?

A. Yes, sir.

the lawsuit was there and then one here where I was served papers.

Q. In those lawsuits, who were the plaintiff?

A. The one in Arkansas was a twenty-two or twenty-four-year-old female that had pneumonia.

Q. And what county?

A. Faulkner County.

Q. Faulkner.

A. Conway, Arkansas. Yes, sir.

Q. And it was an actual lawsuit?

A. Yes, sir.

Q. And then, here, in Louisiana, what parish was the suit served?

A. Here in Lincoln.

Q. Lincoln?

A. Yes, sir.

Q. Do you consider yourself an expert in EMTALA?

A. No, sir.

Q. Have you ever testified as an expert in an EMTALA case, if I haven't already asked you that? I apologize.

A. No, sir. You asked, but I haven't. No, sir.

Q. Okay. Would you be surprised if this child's death was caused by pneumonia and hypoxic brain injury?

A. Would I be surprised? I do believe the patient did have hypoxic brain injury that was on the--that

hospitalization. I don't remember if it said pneumonia as one of the diagnoses.

Q. Would it surprise you that this child had pneumonia?

A. Would it surprise me?

Q. If it turns out that she did?

A. It would be unlikely. It wouldn't surprise me. No, sir.

Q. But it would be unlikely?

A. I would think so. Yes, sir.

Q. And why would you tell the jury that pneumonia would be unlikely in this case?

A. Because she was on an antibiotic at the time. It was started two days prior and she had a chest x-ray done that did not show an obvious pneumonia. It had perihilar infiltrates which is common with asthma.

Q. I'm going to leave this alone, but I just want to make sure I understand.

A. Yes, sir.

Q. You're saying her death was inevitable?

A. I'm saying her death was unfortunate.

Q. And inevitable?

MR. ROBISON: Object to form.

A. I really don't want to say it was inevitable. It was unfortunate. I don't want to use the word inevitable.

Q. Hypothetically, Doc, if this child would have been

hospitalized and hooked up to the monitors, vital signs that we've talked about, would there be a greater than average chance that this child could've been saved?

A. Could they have been? Yes. A lot of people would be saved if they were in the hospital than not. The question goes back to were they inappropriately discharged.

Q. Right.

A. And I don't think they were--it was inappropriate. If the child was in the hospital, would they have found that--that's kind of putting that on the parents and I really don't want to say that, for the parents' sake, to tell them if you'd got the patient back sooner or if you would've stayed with us, that's a hard prediction to make.

Q. If they would have stayed with you? What does that mean?

A. Been admitted to the hospital. Stayed--stayed at the hospital. Believe it or not, sometimes-- I'm going to add this. Admissions are easier than discharges. And so I don't you would risk doing that.

Q. Have you read Dr. Richard Sobel's report in this case?

A. No, sir. I have not.

Q. Have you read his deposition?

A. No, sir. I have not.

Q. Is there any reason why you would not want to read

those documents?

A. I don't think I needed his deposition to form my opinion and I didn't want to be biased on it. I felt like I had enough evidence right here.

Q. Okay.

A. Is he a-- Would you like me to read-- Is he an asthmatic specialist?

Q. No. No.

A. A pediatric specialist?

Q. He's an EMTALA expert.

A. Okay. How do you become an expert in EMTALA?

Q. I think the court probably has the final say on that.

A. Oh.

Q. The effects of Albuterol last four to six hours. Is that correct?

A. The long-term, yes, sir.

Q. So--

A. They can. Yes, sir.

Q. How long does it normally take to know whether Albuterol is working or not working?

A. Usually within fifteen minutes, ten to fifteen minutes. You can--you can see some improvement pretty rapidly.

Q. The home treatments of Albuterol that she received,

A. Well, you just look and see if she has some of the side effects of Albuterol.

Q. Which are?

A. Breathing fast, fast heartrate, anxiousness, nervousness, nausea, upset stomach. Those are the more common ones.

Q. Would you agree with this, Doctor, that needing to use Albuterol more frequently than usual may be a sign that your asthma is destabilizing and you need to seek immediate medical advice?

A. Yes.

Q. Your statement on page 1 of your report, Doctor, you mention that approximately two hours after entering the emergency department, "The patient was stable for discharge." Was that based on a medical examination, that statement?

A. My statement was based on review of the chart.

Q. Okay. Well, when you reviewed the chart, can you show the jury the medical exam that would support that statement?

A. No. That's the statement that the provider wrote.

Q. Oh, okay. I may have attributed that to you. I'm sorry.

A. No. It says the doctor noted on the reassessment that patient's condition had-- I'm sorry.

you just disagree with?

A. I don't disagree with it, but, once again, I think this is inpatient.

Q. Right.

A. I don't see anything that I disagree with. No, sir.

Q. Okay. Do you believe that there's a distinction between the care given to inpatients as those that are receiving treatments in the emergency department?

A. Do I think there's a distinction between inpatient and ER? Yes, sir.

Q. And, in particular, the standard of care involving the oxygen administration. Do you think that's different? That's what I'm trying to figure out, Doc. Let me just--

A. Go ahead. Yes, sir.

Q. --rephrase this.

A. Yes, sir.

Q. In other words, we, at the hospital, have an emergency department--

A. Yes, sir.

Q. --and we have admissions--

A. Yes, sir.

Q. --admitting patients.

A. Yes, sir.

Q. What I'm trying to figure out, do you administer oxygen protocol differently in the emergency room than you

do in the floor of the hospital?

A. I would have to see the two protocols to see if their administration is different. ER is an acute place of acute distress. Hospital inpatient can be not as acute, but can still need it. Like this is talking about recovery patients--

Q. Right.

A. --post-op patients.

Q. Right.

A. So they probably have different protocols, but I have not seen them so I can't tell you what they are.

Q. Okay. Now, Doc, I don't know that you saw all of the records from the Willis-Knighton Bossier. Do you recall those?

A. Of the ER visit?

Q. Yeah.

A. Now, how would I-- I'm not real sure if I'd know if I didn't see all of them.

Q. And that's what I want to talk about here just a second.

A. Okay. Okay.

Q. Before we do that--

A. Yes, sir.

Q. --do you know what a SANE nurse is?

A. Yes, sir.

Q. --the initial ER visit until they pulled the plug on the child. Do you feel like your testimony is consistent with the timeline of facts in that time period?

A. Yes, sir.

Q. Okay. And would you agree with me that if you have some of your facts wrong, that it would give its sway to some of the opinion that you have? In other words, there would be something less than desired about the opinion, it's not exactly accurately, if we're not dealing with the same facts?

A. If my facts were wrong?

Q. Right.

MR. ROBISON: Object to the form.

A. I guess if anybody's facts were wrong, that my opinion would be different. Yes, sir.

MR. BANKS: I think that's all we have, Doctor.

WITNESS: Okay.

MR. BANKS: You have the right to read this and sign it or you can waive that right, whichever you prefer.

WITNESS: I'd like to read it, if that's okay.

MR. BANKS: Sure.

(OFF RECORD)

MR. BANKS: Doctor, what I'd like for you to do is would you make a copy--